Healthpoint

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HOSPITAL MERGERS AND THE PUBLIC INTEREST

The acute hospital industry has undergone intense restructuring, with many closures, conversions, mergers, acquisitions, and affiliations changing the face of the acute hospital sector in major ways. Nationally, the trend began in the 1980s and has continued into the 1990s. Activity in Massachusetts was slower to start but, with hospital deregulation in 1991 and the continued growth of managed care in the state, consolidation has accelerated considerably. This issue of *Healthpoint* examines the trend and explores some of the pertinent policy issues.

Extent of Consolidation

From 1988 to 1997, 15 hospitals out of 101 in Massachusetts closed or converted to other-than-acute services (one hospital converted from non-acute to acute services). There have been 15 mergers, the formation of six other large systems (under either a common parent or sponsor) and four sales of nonprofit hospitals to for-profit systems (See Figure 1). Consolidation activity has accelerated, with more full asset mergers occurring in 1996 (eight) than in the entire 1988 to 1995 period. Fully three quarters of the state's acute hospitals are now part of some larger network. And many of the hospitals still unaligned are in the midst of discussions with national chains or other systems in the state.

Much of the consolidation nationally has included buyouts of lo-

15 Mergers from 1988 to 1996

1 Berkshire Health Systems
(Berkshire Medical Center, Hillcrest and Fairview)
2 Beth Israel Deaconess Medical Center (Deaconess and Beth Israel)
3 Boston Medical Center (University and Boston City)
4 Cambridge Community Health Network (Cambridge and Somerville)
5 Cape Cod Health Systems (Cape Cod and Falmouth)
6 Good Samaritan (Cardinal Cushing and Goddard Memorial)
7 Health Alliance (Leominster and Burbank)
8 Lahey Hitchcock (Lahey and Hitchcock(NH))
9 Memorial (formerly Medical Center of Central Mass;
Worcester Hahnemann and Worcester Memorial)
10 Metrowest (Framingham Union and Leonard Morse)
11 Northeast Health Systems (Beverly and Addison-Gilbert)
12 Saints Memorial (St. John's and St. Joseph's)
13 Salem (North Shore Children's and Salem)
14 Southcoast Health System (Charlton, St. Luke's and Tobey)
15 UniCare Health Systems (Melrose-Wakefield and Whidden)

Six Other Hospital Systems

1 Baystate Health Systems (Baystate, Franklin and Mary Lane)
2 CareGroup (Beth Israel Deaconess, New England Baptist,
Mt. Auburn, Deaconess-Waltham, Deaconess-Nashoba and
Deaconess-Glover)
3 Caritas Christi (Holy Family, St. Elizabeth's, Carney,
Good Samaritan and St. Anne)
4 Partners (Mass. General, Brigham & Women's, Dana-Farber, Salem
and UniCare Health Systems)
5 Sisters of Providence Health Systems (Providence and Mercy)
6 U Mass Health System (U Mass Medical Center, Clinton and
Marlboro, and loosely with Athol, Henry Heywood,
HealthAlliance, Milford-Whitinsville, Harrington, Noble, Holyoke,
Wing, Berkshire and Hubbard)

Four For-Profit Conversions

1 Vencor purchase of Hahnemann
2 Transitional purchase of JB Thomas
3 Columbia purchase of Metrowest
4 OrNda (now Tenet) purchase of St. Vincent

Figure 1

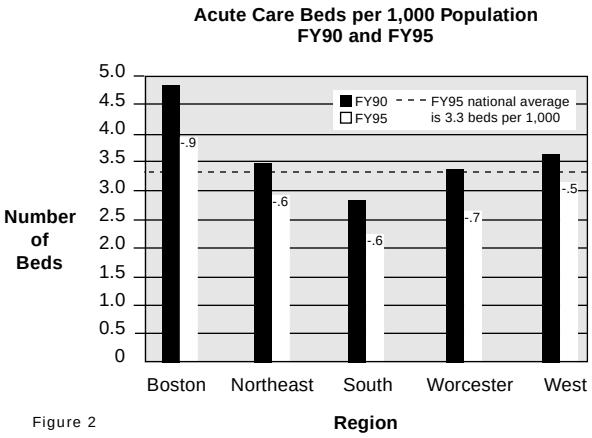

Figure 2

cal hospitals by national chains, whose revenues are growing at a very rapid pace. The largest national chain, Columbia/HCA, increased its net revenues from $300 million in 1990 to $17.2 *billion* in 1995, an increase of over 5,000 percent. Three other national chains - OrNda, Tenet (which is acquiring OrNda) and Catholic Healthcare West - have more than doubled their net revenues in the last five years.

Both Columbia/HCA and OrNda have been active in Massachusetts. Columbia/HCA acquired Metrowest (the merged Framingham Union and Leonard Morse hospitals) last year, and has had recent discussions with many other nonprofit hospitals in the state including, most recently, Neponset Valley Health Systems. OrNda recently acquired St. Vincent Health Care System in Worcester. Lifespan, a nonprofit regional chain, recently announced its intention to purchase New England Medical Center.

The total number of acute hospitals in Massachusetts has dropped from 101 in 1988 to 73 in 1997, and the number of beds per 1,000 population has also been decreasing. Most of this reduction is from hospitals contracting their capacity, rather than from entire hospitals closing. Beds per 1,000, however, continue to be at very different levels across different regions of the state (See Figure 2). Certain areas in the state are still above the U.S. average, while other areas have been consistently below. From the perspective of access and efficiency, it is not clear whether there are now too few beds in these different regions or if capacity could shrink even further without threatening access.

Effects of Consolidation on Industry Efficiency and Prices

Given the driving forces to consolidate in response to the cost-control pressures of managed care, it seems reasonable to ask whether consolidation serves the public interest by promoting a competitive market and a cost-effective health care system. The prevailing theory is that consolidation, along with continued managed care pressures, will reduce incentives for hospitals to duplicate facilities and equipment, and eventually lead to a more rational allocation of resources.

The few studies on cost savings from industry consolidation have been inconclusive as a group on whether mergers and other alliances actually increase efficiency of the system. Some have concentrated on local markets only, where limited competition among a small number of hospitals may have restricted the potential for efficiency improvements. Others have found that efficiencies have been realized but not passed on to purchasers in the form of lower prices. In some cases, where hospitals have traded state imposed post-merger price controls for antitrust approval, there is some evidence of savings. Finally, one national study found that hospitals which merged were able to generate savings, but the researchers could not generalize the results.

A preliminary assessment of cost increases for four of the early mergers in Massachusetts (for which we have at least one full year of post-merger data to assess) is shown in Figure 3. Clearly, there are certain start up costs to consolidation — including the use of attorneys, consultants, and staff time in preparation for the merger, as well as capital costs for restructuring services. For three

of the four mergers, there was an increase in inpatient cost per case mix-adjusted discharge (a measure of efficiency) in the year immediately following the merger. Thereafter, however, the picture is less clear, with some hospital systems showing cost growth lower than the state average for all hospitals, and others higher.

Cost savings, of course, are not the only force driving the rush to consolidate; increased hospital bargaining power is also a powerful incentive. If consolidation results in markets dominated by one or a small number of hospitals, they would be at an advantage in the negotiation process with purchasers and be able effectively to keep any savings that might result from the efficiencies of consolidation. Irrespective of the degree of cost savings achieved, lower prices and premiums are also desirable. Figure 3 shows the change in inpatient net revenue per case mix-adjusted discharge, a good proxy measure for general hospital prices, for the four merged hospitals and the state average. Here, the picture is somewhat clearer for the 1994 to 1995 period. Three of the four merged hospitals show decreases in inpatient prices greater than the decrease in the state average.

Monitoring Consolidation Effects: Competition, Savings and Access

Currently in Massachusetts there is little monitoring of the statewide effects of consolidation on overall market concentration and competition. If consolidation is successful, industry leaders and policy makers should understand how to capture the potential efficiencies hospital mergers offer. This same knowledge would also be helpful to purchasers of health care seeking to achieve savings through reductions in duplication and excess capacity. On the other hand, even if efficiency improves, consolidation could limit competition, enhancing market power and fostering price increases. These potential outcomes suggest that continued post-transaction monitoring of the health care market in Massachusetts is in the public interest.

Access to services in a rapidly changing landscape, particularly when a for-profit conversion is in the works, is a policy concern as well. Most observers agree that measuring changes in access is a complex and multifaceted issue, with no clear cut methodology nor readily available benchmarks on what services are too much, too little or simply adequate for a community's need. Certain questions are bound to arise in the community when hospitals close, merge, consolidate or eliminate services. Are there adequate medical/surgical, pediatric and obstetric beds in a market, given the age and sex distribution of the area's population? Is there adequate emergency/urgent/observation capacity? What, in fact, is adequate? Key aspects of access to care can also include linguistic barriers, outreach and education, and the ability of patients and physicians to exercise preferences for given services. Very few studies have systematically examined the effects of consolidation on a community's access to care. The availability of certain services to a community should be monitored in Massachusetts to ensure that access is not threatened in given markets.

Recently, legislators in Massachusetts filed a bill that would increase scrutiny of for-profit conversions of acute hospitals and HMOs. The legislation would require public hearings on the sale, continuance indefinitely of current levels of free care, terms prohibiting private benefit from the transaction and availability to the

Costs and Revenues
Before and After Mergers

	Change in Cost per Case Mix Adjusted Discharge (CMAD)					Change in Net Revenue per CMAD
	FY91	FY92	FY93	FY94	FY95	FY95
Statewide	2.7 %	2.3 %	0.9 %	-0.5 %	0.9 %	-0.5 %
Metrowest		-4.0 %	4.0 %	1.2 %	-4.9 %	-5.5 %
Saints Memorial		-6.5 %	1.0 %	-3.1 %	4.3 %	N/A
Good Samaritan		3.5 %	7.4 %	-1.9 %	-4.0 %	-6.2 %
Health Alliance					3.5 %	-4.6 %

The white shaded area represents post-merger rates.

Figure 3

public of transaction-related documents. In addition to reviewing these issues, however, there is a need to consider the *overall statewide* changes that have occurred as a result of mergers, like changes in the levels of market-specific competition, the extent to which any realized savings are being passed on to purchasers, and changes in access.

Conclusion

The acute hospital industry has undergone tremendous restructuring over the last five years with mergers, acquisitions, closures, conversions and the development of integrated delivery systems accelerating nationally and here in Massachusetts. Antitrust scrutiny by federal and state agencies has come under fire, particularly in the for-profit conversion area. Lawmakers in Massachusetts have begun to shore up the regulatory agencies' roles in the antitrust arena through regulatory and legislative changes. The goal of these changes is to ensure continued access to care for the uninsured in the wake of for-profit conversions.

There is little evidence from formal studies that hospital consolidation brings efficiencies or the passing on of resultant savings to health care purchasers. In Massachusetts, there is some indication of savings from earlier mergers, and evidence of the contraction of overall capacity in response to market forces, but it is still too soon to assess the economic and access effects of more recent activity. There is, therefore, a need for continued statewide monitoring of the impact of consolidation on market concentration and competition and whether realized cost savings are translated into lower prices for purchasers.

Further Reading

1. Fubini, Susan and Vincent Antonelli, "1996 Industry Outlook", *Healthcare Trends Report*, 10:1 (January 1996).
2. Greene, Jay, "Integrated Delivery Looms as Most Significant Issue for System Executives", *Modern Healthcare* (August, 1995).
3. *The Effects of Hospital Mergers on the Availability of Services*, Office of Inspector General, U.S. Department of Health and Human Services (February 1991).
4. *Effects of Hospital Mergers on Costs, Revenues, and Patient Volume*, Office of Inspector General, U.S. Department of Health and Human Services (June 1992).
5. *Report on 1995 Economic and Financial Trends in Massachusetts Acute Care Hospitals*, Massachusetts Division of Health Care Finance and Policy (1996).

Did you know?

Hospital Facts

	Massachusetts FY96	Massachusetts FY95**	Massachusetts FY94	Massachusetts FY93	US FY95	California FY95
Number of Hospitals						
Acute	79	83	87	89	5,194	424
Non-Acute	56	56	54	54	682	53
Number of Acute Hospital Discharges (thousands)	750	785	823	881	30,945	3,029
Number of Acute Hospital Discharges/1,000 population	124*	130	137	147	117	94
Number of Acute Hospital Days/1,000 population	645*	698	766	873	756	511
Acute Hospital Length of Stay	5.2	5.38	5.68	5.97	6.5	5.4
Percent Inpatient Hospital Revenues	N/A	61%	64%	67%	70%	74%
Percent Outpatient Hospital Revenues	N/A	39%	36%	33%	30%	26%

* Using 1995 population data ** Revised to reflect updated data

Most Frequent Hospital Stays, 1996

Reason for Stay (Diagnosis Related Group)	Total Discharges FY96	Average Length of Stay	Average Charges
Normal neonate and neonate with uncomplicated problems	71,094	2.25	$ 1,125
Vaginal delivery	60,042	2.19	$ 3,558
Psychoses	24,533	10.72	$ 9,970
Heart failure and shock	22,077	5.40	$ 7,435
Simple pneumonia and pleurisy	18,697	5.54	$ 7,137
Cesarean delivery	16,016	4.21	$ 6,716
Circulatory disorders with acute myocardial infarction	14,915	5.62	$ 11,086
Chronic obstructive pulmonary disease	12,643	5.54	$ 6,875
Other digestive system diagnoses*	12,225	4.37	$ 6,478
Nutritional and miscellaneous metabolic disorders	11,587	4.77	$ 6,024

* All medical diagnoses other than digestive malignancy, G.I. hemorrhage & perforation, inflammatory bowel disease, G.I. obstruction, and nonbacterial gastroenteritis & abdominal pain. No surgical procedures included.

Sources: Division of Health Care Finance and Policy; *Hospital Statistics - 1996/97* (American Hospital Association)

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